DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Supportive Living
DSL-810 (Rev. 11/98)

MEDICAID WAIVER PROGRAM
HEALTH REPORT

Personally identifiable information collected on this form is confidential and will be used for identification purposes and to document the individual's health information necessary in determining eligibility for services. Completion of this form is necessary to meet the requirements of Wis. Stats. 46.27(11) and 46.277(4).

INSTRUCTIONS: Complete annually for each CIP II or COP-W participant.

PART A TO BE COMPLETED BY CASE MANAGER

Name of County Agency

Participant's Name (Last, first, MI) | Date of Birth

Name of Participant's Physician | Physician's Telephone Number

Name of Physician's Clinic

PART B TO BE COMPLETED BY PHYSICIAN OR REGISTERED NURSE

1. Participant's Diagnosis *(Please list primary diagnosis first)*
Disabilities/Impairments/Rehabilitation Potential/Prognosis

1a. Condition is considered ☐ stable. ☐ unstable. *(Check one.)*

2. Medications *(Include injections, prescription and over-the-counter medications ordered)*
Name/Dosage/Frequency

2a. Medications should be supervised. ☐ Yes ☐ No *(Check one.)*

3. Physician's Orders:

a. Therapies/Home Health *(Check all that apply.)*

☐ Home nursing care ☐ Home health aide ☐ Personal care
☐ Occupational therapy ☐ Speech therapy ☐ Physical therapy
☐ Other: _____ ☐ Assistance with housekeeping/chores

b. Treatments

☐ Oxygen ☐ Ostomy care ☐ Feeding tube ☐ Ventilator
☐ Dialysis ☐ Suctioning ☐ Parenteral/IV ☐ Range of Motion
☐ IV meds ☐ Transfusions ☐ Severe pain
☐ Decubiti care ☐ Chemotherapy ☐ Radiation
☐ Other: (_____) ☐ Catheter (Type: _____)

4. Ongoing Diagnostic Tests Required Type/Frequency	**5. Diet/Nutrition Special Instructions**

Signature of Physician, Physician Assistant or Registered Nurse | Date Signed

CASE MANAGER: CONTINUE ON REVERSE - page 2 must be completed

PART C TO BE COMPLETED BY A CASE MANAGER OR OTHER PROFESSIONAL FAMILIAR WITH THE INDIVIDUAL

Mobility/Activity Limitations/DME or Adaptive Aids Needed

OTHER INFORMATION: (Mental Status, Communication, etc.)

- For waiver applications include information not found in the Assessment or Narrative.
- For waiver recertification include information missing from page 1 of this Health Form or any additional information which substantiates the level of care determination on the COP Functional Screen.

Name of person filling out Part C	Title